

**AUTHORIZATION FOR TREATMENT:** I understand that I have a health concern which requires diagnosis and treatment, and I authorize Hudson Physicians to provide such diagnosis and treatment. I understand that diagnostic procedures and medical care ordered by my physician are in his/her opinion necessary to treat my health concerns.

**PAYMENT AUTHORIZATION:** I request that payment be made on my behalf to Hudson Physicians for services furnished to me by Hudson Physicians. I authorize Hudson Physicians to release to the Centers for Medicare & Medicaid Services and its agents, any state Medicaid agency, and any other third party payor all medical or other information that is needed to determine the benefits payable for health services. I agree to pay the charges for the care and treatment rendered to me that are not covered by insurance.

**RECORD RELEASE:** I hereby authorize the release of my medical information (including information, if any, about substance abuse, mental health and HIV/AIDS) to my referring provider and any health care provider currently involved in my treatment.

Patient's Printed Name: \_\_\_\_\_

\_\_\_\_\_  
Date Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor

If signed by patient representative or parent/legal guardian, indicate relationship to patient:  
\_\_\_\_\_

**CONSENT FOR TREATMENT OF MINORS:** Hudson Physicians requires that a parent or legal guardian accompany any minor children (17 years old or younger) to their medical appointments. In the event that a parent or legal guardian is unable to accompany a minor child to a medical appointment, the parent or legal guardian must sign this Consent for Treatment of Minors to be kept on file at Hudson Physicians Clinic.

Name of child: \_\_\_\_\_

Name of parent or legal guardian: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

I authorize care and treatment for my unaccompanied child. The following individuals may authorize treatment for my child:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I agree to reimburse Hudson Physicians for the cost of rendering services to my child in my absence.

\_\_\_\_\_  
Date Signature of parent or legal guardian

**REQUIRED SIGNATURE (UPDATE ANNUALLY)**